Case Management Selection

Applicant Name: _____
Last Name *First Name*

Legal Guardian: _____
Last Name *First Name*

Wyoming Department of Health
Commit to your health.
Behavioral Health Division

Please Check the Type of Waiver: ☐ Comprehensive Waiver
☐ Supports Waiver ☐ Acquired Brain Injury (ABI) Waiver

Acknowledgement of Choice of Providers and Case Manager Conflict of Interest Disclosure

Please *initial* each line to verify that services available through the waiver program have been explained to you.

____ I understand that I have the ability to make decisions regarding what services will be provided and which providers we will work with while he/she is a waiver participant.

____ I understand that I have a right to request informal dispute resolution or an Administrative Hearing if not given the choice of providers.

____ I understand that I can choose a case manager not affiliated with any of my other services; however, if the case manager is providing other services on my plan or works for an organization providing me other services, this may be a conflict of interest and it must be disclosed.

Targeted Case Manager & Case Manager Selection

A list of certified case managers available in my area/region has been shared with me and my questions have been answered. I have chosen the following individual to act as my case manager, to assist in gathering the necessary information to prepare my clinical eligibility, and if eligible for services, to assemble and submit the Individualized Plan of Care. I understand that I may choose a different case manager at a later date.

Case Manager Name:_____ Organization: _____

Federal Provider ID (NPI):_____ Wyoming Provider ID: _____

If this selection is to make a change, my current Case Manager is: _____

Federal Provider ID (NPI):_____ Wyoming Provider ID: _____

Effective Date of Change to New Case Manager:_____/_____/_____

Back Up Case Manager Name:_____ Organization: _____

Consent for Information Release

Please *initial* each line verifying your understanding of this information.

____ I agree to participate in assessments/screenings to determine clinical eligibility and the need for HCBS waiver services.

____ I authorize the release of information by my physician, hospital, community mental health center, other social service providers, school, health service providers and family members to and among state agencies and their agents on my child's medical condition and other relevant information necessary to determine appropriate HCBS waiver services. I understand I may revoke this release of information in writing at any time.

Signatures

_____ ___/___/____
Signature of Applicant or Guardian Date

_____ ___/___/____
Signature of Selected/Current Case Manager Date

_____ ___/___/____
Signature of Witness Date
(Required if the signature is marked with an "X")

_____ ___/___/____
Signature of New Case Manager Date

Complete this form and mail to the BHD Participant Support Specialist.

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